

Child-Parent Psychotherapy (CPP)

Introduction and Implementation Planning

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Topics

- I. CPP Client Population**
- II. CPP Model**
- III. Training Protocol**
- IV. Expectations to Maintain Fidelity**
- V. Implementation and Planning**

CPP CLIENT POPULATION

OVERVIEW

- According to Centers for Disease Control and Prevention (2008), 1 in 50 infants (birth – 12 months) are victims of nonfatal child abuse and neglect in a year
- The extensive research on child abuse and neglect indicates:
 - Child abuse and neglect have enduring physical, intellectual and psychological repercussions, which persist into adolescence and adulthood
 - Abuse and neglect adversely affect attachment, and subsequently the child's physical, behavioral, cognitive, and social functioning.

OVERVIEW

- For Children who have been exposed to Domestic Violence, research indicates:
 - these children are 15 times more likely to be abused than their peers
 - they are at serious risk of sexual abuse
 - these children have twice the rate of psychiatric problems than their peers

Appropriate Target Population:

- As a relation-based dyadic intervention, Child-Parent Psychotherapy (CPP) targets the caregiver-child relationship, hence parents should be available to participate in treatment
- Children birth to 5 years of age, who have experienced one or more traumas (e.g., child abuse, sexual abuse, domestic violence, psychological maltreatment, serious accident, medical illness, natural disaster, long term separation from attachment figure, forced removal, etc.)

Appropriate Clients:

- DMH implementation of CPP will target infants through 5 years of age, and their parent (primary care provider) specifically, children experiencing trauma-related psychological distress, such as:
 - Re-experiencing of trauma (e.g., post-traumatic play, distress at reminders of situation)
 - Numbing of affect (e.g., social withdrawal, affective constriction, developmental stagnation or losses)
 - Increased arousal (e.g., heightened startle response, decreased concentration, hypervigilance)

Appropriate Clients: Culturally Diverse Population

- Applicable for both males and females
- Successfully used with children of diverse SES
- Implemented with multiracial clients including African Americans, Asians, Caucasians, Latinos (from Mexico , Central and South America), Native Americans, recent immigrants and individuals with a wide range of acculturation levels
- Material is available in English and Spanish

Appropriate Clients: Culturally Diverse Population

- CPP focuses on the impact of trauma on the parent-child relationship while integrating the importance of the family's culture and cultural belief system (e.g., spirituality, parenting practices, discipline, immigration experiences, historical trauma, etc.)

Clients for Whom CPP may not be the Appropriate First-line of Treatment

- CPP was not developed for children with developmental delays
- CPP was not designed to be conducted in a group format
- CPP is not the treatment of choice if the parent or caregiver is not available to participate in treatment

CPP MODEL

What is CPP?

- Child-Parent Psychotherapy is a Dyadic attachment-based treatment for trauma-exposed children, ages birth to age 5
- The child is seen with his/her primary caregiver
- The parent-child dyad is the unit of treatment (client)

What is CPP?

- While based in attachment theory, CPP integrates a multi-theoretical treatment approach:
 - Psychodynamic
 - Developmental
 - Trauma
 - Social learning
 - Cognitive behavioral

CPP: Key Components

- Provide developmental guidance to parents
- Attend to family's cultural norms
- Develop collaborative family engagement
- Provide concrete assistance with problems of daily living
- Help parents provide physical safety for themselves and their children
- Help parents provide emotional safety
- Improve the child-caregiver relationship
- Joint construction of a trauma narrative

CPP Primary Goals

1. Support and strengthen the caregiver-child relationship as a vehicle for restoring and protecting the child's mental health
2. Restore levels of functioning in development, daily activities, and adaptive coping
3. Develop and maintain regular levels of affective regulation
4. Establish trust in body sensations

CPP Primary Goals

5. Achieve reciprocity in intimate relationships
6. Increase capacity to respond realistically to threats
7. Differentiate between reliving and remembering
8. Develop a new perspective on the traumatic experience (normalization of the traumatic responses)

CPP TREATMENT MODEL

- Weekly sessions that focus on child-parent dyad
- Sessions are typically 60 – 90 minutes
- Treatment occurs over the course of 50 weeks
- CPP is typically conducted in an outpatient clinic, adoptive home, birth family home, or foster home

CPP TREATMENT MODALITIES

- Play, physical contact, & language
- Unstructured developmental guidance
- Modeling appropriate protective behavior
- Interpretation
- Emotional support
- Crisis intervention/case management

CPP Evidence Base

- CPP is one of the few empirically validated treatments available for children ages birth to five
- One of the few empirically validated treatments routinely implemented with children of various ethnic backgrounds

CPP Evidence Base

- Strong evidence base supporting treatment effectiveness
 - At post-treatment, children showed significantly greater reductions in total behavior problems and traumatic stress
 - At post-treatment, parents showed significantly greater reductions in avoidant symptomatology
 - Results indicate significantly greater change in attachment, relative to standard community treatment
 - Studies examining clients at 6-month follow up, revealed sustained improvements in children's behavior problems and parent symptoms

CPP PEI Outcomes for Children

- Decreased symptoms of Trauma (Trauma Symptom Checklist for Young Children)
- Improvement of parent-child attachment, communication, discipline and parenting confidence (Parent Relationship Questionnaire)
- Provision of prevention and early intervention services to underserved populations (Utilization)

CPP

Staffing for Sustainability

- LAC DMH minimum model staffing:
 - 1 licensed supervisor
 - 2 clinicians (MA level or higher)
 - 1 administrator (primarily for implementation, policy and decision making)
- Developer expects clinicians will have clinical experience/expertise working with the birth to five population
- Developer expects clinicians will have an understanding of trauma among the birth to five population

Sustainability: Further considerations

- Agency should have a robust birth to five client population
- Clinicians are expected to have clients within 2 – 4 weeks, following the training
- Since this is a 50-week treatment model, agency staff should understand and be able to enforce the agency's attendance policy

Training Protocol

DMH PEI TRAINING PROTOCOL

- Clinicians and supervisors must complete the initial and booster training sessions, in totality, and participate in all mandatory consultation calls
- Read two books prior to attending the initial training (DMH will provide prior to training):
 - *Don't Hit My Mommy*
 - *Psychotherapy with Infants and Young Children*

DMH PEI TRAINING PROTOCOL

- **Mandatory Initial Training:**

- Clinical staff – 2.5 days
- Supervisors – 2.5 days of clinical training + ½ day (third training day) focusing on supervision, implementation and agency issues
- Administrator – ½ day (third training day) focusing on supervision, implementation, agency and policy issues

- **Mandatory 3-month Booster Training:**

- Clinical staff - 2 days
- Supervisors – 2 days of clinical training + ½ day (third day) focusing on supervision, implementation and agency issues
- Administrator – ½ day (third day) focusing on supervision and implementation/policy issues

DMH PEI TRAINING PROTOCOL

- **Mandatory 6-month Booster Training:**
 - Clinical staff – 1.5 days
 - Supervisors – 1.5 days of clinical training + ½ day (second day) focusing on supervision, implementation and agency issues
 - Administrator – ½ day (second day) focusing on supervision, implementation, agency and policy issues
- Participation in each of the mandatory bimonthly consultation calls with CPP trainers
- The first DMH training:
April 26 - 28

EXPECTATIONS FOR MAINTAINING FIDELITY

Expectations for Fidelity

- Agency will complete the Organizational Readiness and Capacity Assessment and participate in a pre-implementation phone conference with the developers
- Agency will ensure staff read the required texts for this training
- Agency will ensure staff participate fully in the initial and booster training sessions, and each of the bimonthly consultation calls

Expectations for Fidelity

- Agency will require staff to complete the Child-Psychotherapy Knowledge test
- Agencies will ensure staff participation in regular supervision with a supervisor being trained and supervised in CPP
- Fidelity instrument (Evaluating use of Core Elements of Child-Parent Psychotherapy) will be completed and submitted as required by trainers

Expectations for Fidelity

- Agencies are responsible for additional training fees associated with replacing a therapist
- Agencies will adhere to DMH training protocol when replacing clinicians and expanding treatment teams
- Agency staff will be trained by certified trainers and/or trainers recognized by CPP developers

Expectations for Fidelity

- New clients will be referred to treatment within two weeks of initial contact
- Identified outcome measures will be administered at intake, 6-months, 12-months, and termination, and data will be submitted to on a schedule and in a format designated by DMH

Implementation and Planning

Implementation Planning: Referrals

- Agency should have an established birth to five client population
- Have an established process for following-up with referrals
- Identify who will be responsible for coordinating
- Clarify inclusion or exclusion criteria with intake workers

Implementation Planning

- Identify clinicians who have strong clinical experience with birth to five population
- Identify clinicians who have clinical expertise in child trauma
- Determine how agency will enforce its attendance policy
- Determine how agency will enforce parent/caregiver participation

Implementation Planning:

- Identify what other duties will the CPP clinicians will have
- Determine who will supervise the CPP practitioners
- Clarify with supervisor that he/she is expected to carry a caseload
- Determine whether supervisors will be responsible for supervising other programs?

Implementation Planning: Fidelity and Evaluation

- Who will be responsible for insuring appropriate and timely administration of outcome evaluation tools?
- Who will be responsible for data collection, interpretation, feedback to staff, and submittal?
- What barriers to outcome data collection, entry or submittal do you anticipate?

Implementation Planning: Administrative Oversight

- What administrator is committed to ensuring training plan & CPP Fidelity?
- What administrator will monitor fidelity and outcome reports and oversee any needed corrections?
- How will staff attrition be managed?

Contact Information

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